

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 227 Primary Registration District No. 5804 Registrar's No. 29

63-020845

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0690

2 0690

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12 90-0

13 2-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUN 14 1963

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON</u>		Length of stay in 1b <u>31 YRS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 MI. S.W. OF PARIS, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS <u>1/2 MI. S.W. OF PARIS, MO.</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD LYNN HALBERSTADT</u>			4. DATE OF DEATH Month Day Year <u>JUNE 12, 1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY FARMING</u>	9. AGE (last birthday) <u>72</u>
11a. FATHER'S NAME <u>CASPER HALBERSTADT</u>		11b. MOTHER'S MAIDEN NAME <u>AMERICA (UNKNOWN)</u>	11. BIRTHPLACE (City and state or country) <u>PA.</u>
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>		13. SOCIAL SECURITY NO. <u>[REDACTED]</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
14. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Brain Thrombosis</u> DUE TO (c) <u>[REDACTED]</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF HUSBAND OR WIFE <u>MABEL HALBERSTADT</u> Address <u>R-3 PARIS, MO.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>KKK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 20 - '63</u> to <u>June 12 '63</u> and last saw him alive on <u>June 11 - 63</u> Death occurred at <u>6:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>PARIS, MO.</u>	22c. DATE SIGNED <u>6/12/1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6/14/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE CEM.</u>	23d. LOCATION (City, town, or county) <u>PARIS, MISSOURI</u>
24. FUNERAL DIRECTOR <u>E. H. AGNEW - PARIS, MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>June 12 - 1963</u>	26. REGISTRAR'S SIGNATURE <u>J. A. Barnett</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

JUN 24 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert E. Wood

Licensed Embalmer No. 5205

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.